DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FOLLOWING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL HEALTHCARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: SPA #02-19	2. STATE: Kansas
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2002	

5. TYPE OF PLAN MATERIAL (Check *One*):

☐ NEW STATE PLAN ■ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT
42 CFR 447.252	a. FFY 2002 $ 0 b. FFY 2003 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Pages 26, 27, 28, 30 & 31	Attachment 4.19-A Pages 26, 27, 28, 30 & 31

10. SUBJECT OF AMENDMENT:

Disproportionate Share

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED: Janet Schalansky is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL: Janet Schalansky by LK H	16. RETURN TO: Janet Schalansky, Secretary Social & Rehabilitation Services Docking State Office Building 915 SW Harrison, Room 651S Topeka, KS 66612-2210
13. TYPED NAME: Janet Schalansky	
14. TITLE: Secretary	
15. DATE SUBMITTED: August 27, 2002	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 08/29/02	18. DATE APPROVED: NOVEMBER 25, 2002

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2002	20. SIGNATURE OF REGIONAL OFFICIAL: Charles Brantley Smith
21. TYPED NAME: ~~Thomas W. Lenz~~ CHARLENE BROWN	22. TITLE: Deputy Director, CMSO ~~ARA for Medicaid & State Operations~~

23. REMARKS:

SPA CONTROL

Date Submitted: 08/27/02
Date Received: 08/29/02

FORM HCFA-179 (07-92) Instructions on Back

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

5.0000 Reimbursement for NF Services (Swing Beds) in General Hospitals

Reimbursement for NF services (swing beds) provided in general hospitals (swing bed hospitals) shall be pursuant to 42 CFR 447.280.

6.0000 Disproportionate Share Payment Adjustment

The Medical Assistance Program of the State of Kansas shall make a reimbursement adjustment for disproportionate share hospitals located within the State of Kansas. The reimbursement adjustment for disproportionate share hospitals shall be made for hospitals eligible under either criteria contained in 6.1000 or 6.2000 below.

Hospitals to be eligible under either Option 1 or Option 2 must have at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under the State Plan, except where the hospital serves predominantly individuals under 18 years of age, or where non-emergency obstetric services to the general population were not offered as of July 1, 1988. In rural areas the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. Please see section 6.50000 for addition instructions.

6.1000 Option 1

If determined eligible for disproportionate share payment adjustment according to P.L. 100-203, Section 4112, Subsection (b)(1)(A), and the Medicare Catastrophic Coverage Act, (eligibility shall be determined for a maximum of one year per determination), a hospital shall be reimbursed for disproportionate share according to the following. The mean Medicaid/MediKan inpatient utilization rate for Kansas hospitals receiving Medicaid/MediKan payments plus one standard deviation shall be subtracted from each hospital's Medicaid/MediKan inpatient utilization rate. If the remainder is greater than zero, the remainder shall be divided by 2, 2.5% shall be added, and the result shall represent the percentage payment adjustment. This percentage payment adjustment shall be multiplied by the Kansas Medicaid/MediKan annual payment for inpatient hospital services made for the state fiscal year ending two years prior to the year of the administration of a disproportionate payment adjustment. For example, 1995 state fiscal year payment adjustment shall be based upon the state fiscal year 1993 Kansas Medicaid/MediKan annual payment. The mean Medicaid/Medikan inpatient utilization rate shall include Medicare days paid by Medicaid. In order to be eligible, the hospital must have a minimum medical utilization of 1%, as determined in Option 1. Medicaid/MediKan utilization shall be based upon the Medicare cost report which must be available as of the start of the state fiscal year for which payments are to be made.

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6.2000 Option 2

Hospitals are determined to be eligible under the low-income utilization rate if, based upon the computations below, line C1 exceeds 25%. Hospitals shall be sent a form specifying the eligibility criteria prior to the start of each state fiscal year. Eligibility shall be determined for a maximum of one year per determination. Only hospitals returning the form may be potentially eligible for Option 2. This form shall be compared with the Medicare cost report (HCFA-2552-92), paid Medicaid/MediKan claims summary and other information as necessary in order to verify the data submitted. The Medicare cost report must be available no later than the start of the state fiscal year for which payments are being made.

All data below, except where specifically noted, should only include inpatient hospital data. SNF, ICF, long term care units, home health agency, swing bed, ambulance, durable medical equipment, CORF, ambulatory surgical center, hospice, rural health clinic, or non-reimbursable cost centers shall not be considered. Although specific references are given to the Medicare cost report, other line numbers may also be applicable where the hospital uses a blank line and adds an alternative title to the forms.

A1. Medicaid/MediKan inpatient payments for the most recent available hospital fiscal year, excluding disproportionate share payments.

A1a Medicaid/MediKan outpatient payments for the most recent available hospital fiscal year. Outpatient payments only includes payments made to hospitals for hospital outpatient services.

A2 & A3. Other state and local government income from Medicare Worksheet G-3, Governmental appropriations (Line 23), excluding Disproportionate share payments.

A4. Total Medicaid/MediKan, State and local government funds (A1+A1a+A2+A3).

A5. Inpatient Revenues from Medicare worksheet G-2, Column 1, Total inpatient routine care services (line 16) + ancillary (line 17) + outpatient (line 18) - swing bed (lines 4 & 5) - SNF (line 6) - ICF (line 7) - LTCU (line 8).

A6. Total patient revenues from Medicare Worksheet G-2, Column 3 (line 25).

A7. Ratio of inpatient revenues to total patient revenues (A5 / A6).

A8. Contractual allowances and discounts from Medicare Worksheet G-3 (line 2).

A9. Inpatient share of contractual allowances and discounts (A7 X A8).

A10. Net inpatient revenue (A5 - A9).

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

6.2000 continued

A11. Ratio of Medicaid/MediKan, State, and local government funds to net inpatient revenue (A4 /A10).

B1. Inpatient charity care charges, excluding Medicaid/MediKan, Medicare, contractual allowances and discounts.

B1a. Outpatient charity care charges, excluding Medicaid/MediKan, Medicare, contractual allowances and discounts. Outpatient services only includes services provided by the hospital and reported in the Medicare cost report as outpatient services.

B2. Other State and local government funds (A2 + A3).

B3. Ratio of inpatient revenues to total patient revenues (A7).

B4. Inpatient portion of State and local government funds (B2 X B3).

B5. Hospital costs from Medicare worksheet B Part I, total column, subtotal (line 95) - Rural Health Clinic (line 63) - Ambulance (line 64) - DME (lines 65 & 66) - Medicare (line 69) - unapproved teaching (line 70) - HHA (lines 71 through 81) - CORF (line 82) - HHA (lines 89 & 90) - ASC (line 92) - Hospice (line 93).

B6. Hospital revenue from Medicare worksheet G2, column 3, total patient revenue (line 25) - swing bed (lines 4 & 5) - SNF (line 6) - ICF (line 7) - LTCU (line 8) - HHA (line 19) - Ambulance (line 20) - CORF (line 21) - ASC (line 22) - Hospice (line 23).

B7. Cost to revenue ratio (B5 / B6).

B8. Hospital revenue attributable to the inpatient portion of State and local government funds (B4 / B7).

B9. Unduplicated charity care charges (B1+B1a-B8. If this is negative, use 0).

B10. Ratio of unduplicated charity care to total inpatient revenue (B9 / A5).

C1. Low-Income utilization rate (A11 + B10).

D1. Uninsured Charges. The uninsured are only those patients shown in charity care (B1+B1a) for which no other payment is received.

KANSAS MEDICAID STATE PLAN

Disproportionate Share Low-Income Utilization

All data on this schedule, except where specifically noted, should only include hospital inpatient data. Do not include SNF, ICF, long term care units, home health agency, swing bed, ambulance, durable medical equipment, CORF, ambulatory sugical center, hospice or non-reimbursable cost centers. Although specific line numbers from the Medicare Cost Reports are given, if blank lines on the Medicare Cost Report are used by the hospital, the blank lines should also be included or excluded, as appropriate, where there are similar refcrences.

Hospital Name _____

Kansas Medicaid Number _____ **Fiscal Year Ending** _____

A1 Medicaid/Medikan inpatient payments for the most recent available hospital fiscal year, excluding disproportionate share payemnts. Contact Health Care Policy (785-296-3981) for a log summary. _____

A1a Medicaid/MediKan outpatient payments for the most recent available hospital fiscal year. Outpatient payments only includes payments made to the hospital for outpatient services. _____

Other State and local government income. Provide source and description. Disproportionate share payments should not be included here. (Medicare Worksheet G-3, Governmental appropriations (Line 23))

A2 _____

A3 Total Medicaid/Medikan, State and local government funds. (A1 + A1a + A2) _____

A4 Inpatient Revenues (Medicare Worksheet G-2 Column 1, Total Inpatient Routine Care Services (Line 16) + Ancillary (Line 17) + Outpatient (Line 18) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU (Line 8)-other appropriate lines) _____

A5 Total patient revenues (Medicare Worksheet G-2, Line 25, Column 3) _____

A6 Ratio of inpatient revenues to total patient revenues (A4 ÷ A5) _____

A7 Contractual Allowances and discounts (Medicare Worksheet G-3, Line 2) _____

A8 Inpatient share of contractual allowances and discounts (A6 × A7) _____

A9 Net inpatient revenue (A4 - A8) _____

A10 Ratio of Medicaid/Medikan, State and local government funds to net inpatient revenue (A3 ÷ A9) _____

B1 Inpatient charity care charges. Charity care is considered to be any unpaid charge made directly to a patient where a reasonable effort has been made to collect the charge. This would include spendown incurred by a Medicaid recipient, the deductible on insured patients, and the entire charge of private pay patients, providing a reasonable attempt to collect the amount due has been made. This should also include the portion of any sliding fee scale which is not billed to the patient. It would not include any amount billed but not paid by a third party, such as Medicaid, Medikan, Medicare, or insurance (contractual allowance) or third party or employee discounts. Information to support this number must be maintained by the hospital and is subject to review. _____

B1a Outpatient charity care charges. Outpatient services only includes services provided by the hospital and reported in the Medicare cost report as outpatient services. All other requirements in B1 apply here. _____

B2 Other State and local government funds (A2) _____

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B3	Ratio of inpatient revenues to total patient revenues (A6)	
B4	Inpatient portion of State and local government funds (B2 × B3)	
B5	Hospital costs (Medicare Worksheet B Part I, Total Column, Subtotal (Line 95) - SNF (Line 34) - ICF (Line 35) - LTCU (Line 36) - Rural Health Clinic (Line 63) - Ambulance (Line 65) - DME (Line 66 & 67) - Medicare (Line 69) - Unapproved Teaching (Line 70) - HHA (Line 71 through 81) - CORF (Line 82) - HHA (Line 89 & 90) - ASC (Line 92) - Hospice (Line 93))	
B6	Hospital revenue (Medicare Worksheet G2, Column3, Total Patient Revenue (Line 25) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU(Line 8) - HHA (Line 19) - Ambulance (Line 20) - CORF (Line 21) - ASC(Line 22) - Hospice (Line 23))	
B7	Cost to revenue ratio (B5 ÷ B6)	
B8	Hospital revenue attributable to the inpatient portion of State and local government funds (B4 ÷ B7)	
B9	Unduplicated charity care charges (B1 + B1a - B8 (if negative use 0))	
B10	Ratio of unduplicated charity care to total inpatient revenue (B9 ÷ A4)	
C1	Low-Income utilization rate (A10 + B10)	

Section D only applies if C1 exceeds 0.25 and there is a minimum 1% Medicaid utilization.

D1	Hospital Limitation. All hospital are limited to no more than 100% of their net Medicaid cost plus the cost of the uninsured for FY 2001. The uninsured are only those patients shown in charity care (B1) for which no other payment is received. **Report the uninsured here.** Do not report Medicaid here. This line must be completed or no disproportionate share payments will be made.	
D2	Cost of the uninsured (D1 x B7)	
D3	Loss on Inpatient Kansas Medicaid payments (Computed by Medicaid)	
D4	Subtotal of eligible losses (D2+D3)	
D5	Kansas Medicaid Inpatient Days in last available fiscal year of hospital	
D6	All Medicaid Inpatient Days in last available fiscal year of hospital	
D7	Kansas portion of Medicaid inpatient days (D5 ÷ D6)	
D8	Estimated Disproportionate Share Payments (D7 x D4)	

I declare that I have examined this statement, and to the best of my knowledge and belief, it is true, correct, complete, and in agreement with the books maintained by the facility. **I understand that the misrepresentation or falsification of any information set forth in this statement may be prosecuted under applicable Federal and/or State law.**

Signature of Officer/Administrator

Title

Date